## Walgreens

## Healthcare Plus



## REGISTRATION & PRESCRIPTION ORDER FORM

Please PRINT clearly using UPPERCASE letters. Use black ink only. Enclose this form with your mail service prescription.

## **CITY OF TEMPE**

GROUP NO.: 512220 INTERCOM: WHP UPI: WHP267

MEMBER ID NUMBER (VERY IMPOR	,		Імроі	RTANT				
Name (First, Last)		It is standard pharmacy practice to substitute generic equivalents for brand-name drugs whenever possible. Walgreens Healthcare Plus will dispense an FDA-approved generic equivalent whenever available, permitted by your prescriber, and allowable by law. If you do not want a generic equivalent, please call our Customer Service number to advise.						
E-mail address  Date of Birth (MM/DD/YYYY)  Male Female								
								Address (please do not use P.O. Bo
City	State ZIP Code							
Daytime Phone	Evening Phone							
( )	( )		(required at t					
ALLERGIES: ☐ 70-Penicillin ☐ Other (list): ☐ No Known ☐ 87-Sulfa		Rx Type	No.	Cost (ea.)	Subtotal			
	— — —			\$*	\$			
☐ No Known ☐ 60	00-Glaucoma 00-Stomach Disorders 00-Thyroid Disease	Brand		\$*	\$			
	00-Triyroid Disease	TOTAL AMOUNT ENCLOSED \$						
☐ 400-Heart Disease ☐ Other (list):		Signature	Signature (for credit card):					
Dr. Name (print) Dr. P	hone (very important)							
☐ Check if patient needs snap-on ca	•							
☐ Check if patient needs Spanish vi		_						
CREDIT CARD NUMBER (VISA, Mas	sterCard, Discover, Amer	ican Express; <b>no</b>	cash, please) (	CHEDIT CARD	EXPIRATION			
				/				
Checks payable to: Walg					8-9061			
	SERVICE: 1-800-345-1 E: 1-800-RX-REFILL (1				7\			
PLEASE NOTE: By submitting thi								

(and other necessary parties) as required to process your prescriptions and their refills under your benefit plan. Thank you for your order. Please allow two weeks for delivery from the date you mail your order.



#2 DEPENDENT I	NFORMAT	TION	#
Name (First, Last)			Name (First
E-mail address			E-mail addre
Date of Birth (MM/DD/YYYY)			Date of Birt
/ / /		☐ Male☐ Female☐	/
Address (please do not use P.O. I	Box)		Address (ple
City	State	ZIP Code	City
Daytime Phone	Evening	Phone	Daytime Ph
( )	(	)	( )
ALLERGIES:		ther (list):	ALLERGIES  ☐ No Know ☐ 32-Code
	500-Glauco	ama .	HEALTH CO
☐ No Known		ch Disorders	☐ No Know☐ 200-Dial
= = =	800-Arthriti	-	□ 300-Нур
	Other (list):		☐ 400-Hea
Dr. Name (print) Dr.	Phone (ver	ry important)	Dr. Name (p
☐ Check if patient needs snap-on			☐ Check if p
☐ Check if patient needs Spanish	vial labels		☐ Check if p
#3 DEPENDENT I	NFORMAT	ΓΙΟΝ	#
Name (First, Last)			Name (First
E-mail address			E-mail addre
E-mail address  Date of Birth (MM/DD/YYYY)		¬ □ Male	E-mail addre
Date of Birth (MM/DD/YYYY)		☐ Male☐ Female	Date of Bir
	Box)		
Date of Birth (MM/DD/YYYY)	Box)		Date of Bir
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. I	State	☐ Female	Date of Bird // Address (place) City
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. I		☐ Female	Date of Bir
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. I  City  Daytime Phone ( )	State  Evening	ZIP Code Phone	Date of Bird Address (ple
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. I	State  Evening	☐ Female	Date of Bird Address (ple City  Daytime Phe ( ) ALLERGIES
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. I  City  Daytime Phone ( )  ALLERGIES:  70-Penicillir	State  Evening (	ZIP Code Phone	Date of Bird Address (pleto) City  Daytime Photo ( ) ALLERGIES  No Know
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. I  City  Daytime Phone ( )  ALLERGIES:	State  Evening (	ZIP Code  Phone ) ther (list):	Date of Bird
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. I  City  Daytime Phone ( )  ALLERGIES:	State  Evening (  n □ □ 0  line 500-Glauco	ZIP Code  Phone ) ther (list):	Date of Bird Address (pleta) City  Daytime Photo ( ) ALLERGIES  No Know 32-Code HEALTH CO
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. I  City  Daytime Phone ( )  ALLERGIES:	Evening (    Compared to the c	ZIP Code  J Phone ) ther (list):  oma ch Disorders d Disease	Date of Bird Address (plet City  Daytime Photo ( ) ALLERGIES  No Know 32-Code HEALTH CO No Know 200-Diat
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. II  City  Daytime Phone ( )  ALLERGIES:	Evening (    Image: Control of the c	ZIP Code  J Phone ) ther (list):  oma ch Disorders d Disease s	Date of Birt Address (ple City  Daytime Phe ( ) ALLERGIES No Knov 32-Code HEALTH CC No Knov 200-Diat 300-Hyp
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. II  City  Daytime Phone ( )  ALLERGIES:	Evening (    Evening (   O   Iline   500-Glaucce 600-Stoma 700-Thyroic 800-Arthriti Other (list):	ZIP Code    Phone   )   ther (list):    Disorders   d Disease   s	Date of Birt Address (ple City  Daytime Phe ( ) ALLERGIES No Knov 32-Code HEALTH CC No Knov 200-Diat 300-Hyp 400-Hea
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. II  City  Daytime Phone ( )  ALLERGIES:	Evening (    Evening (   O   Iline   500-Glaucce 600-Stoma 700-Thyroic 800-Arthriti Other (list):	ZIP Code  J Phone ) ther (list):  oma ch Disorders d Disease s	Date of Bird Address (plet City  Daytime Photo ( ) ALLERGIES  No Know 32-Code HEALTH CO
Date of Birth (MM/DD/YYYY)  Address (please do not use P.O. II  City  Daytime Phone ( )  ALLERGIES:	Evening (    Compared to the c	ZIP Code    Phone   )   ther (list):    Disorders   d Disease   s	Date of Biri

#4 DEPENDENT INFORMATION								
Name (First, Last)								
E-mail address								
Date of Birth (MM/DD/YYYY)			ا ٦		Male			
					Female			
Address (please do not use P.O. Box)								
City	S	State	Z	IP (	Code			
-								
Daytime Phone	E	vening	g Pho	one	!			
	(		)					
ALLERGIES:   70-Penicill	in		ther	(lis	t):			
☐ No Known ☐ 87-Sulfa								
☐ 32-Codeine ☐ 93-Tetracy	cline							
HEALTH CONDITIONS: □	500-	Glauc	oma					
		Stoma						
		Thyroi		sea	se			
= = =		Arthrit						
		er (list)						
Dr. Name (print)	r. Pho	ne (ve )	ry im	poi	rtant)			
☐ Check if patient needs snap-or	n caps	S						
☐ Check if patient needs Spanisl	h vial	labels						
#5 DEPENDENT INFORMATION								
#5 DEPENDENT			TION	1				
#5 DEPENDENT Name (First, Last)			TION	ı				
Name (First, Last)			TION	ı				
			TION	I				
Name (First, Last)					Mala			
Name (First, Last)  E-mail address					Male			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)	INFO	DRMA			Male Female			
Name (First, Last)  E-mail address	INFO	DRMA						
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)	INFO	DRMA	]					
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.	Box)	ORMA'			Female			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.	Box)	ORMA			Female			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.	Box)	ORMA'			Female			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.	Box)	DRMA State		IP (	Female			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.  City  Daytime Phone ( )	Box)	DRMA State	Z g Pho	IP (	Female			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.  City  Daytime Phone ( )  ALLERGIES:   70-Penicill	Box)	DRMA State	Z g Pho	IP (	Female			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.  City  Daytime Phone ( )  ALLERGIES:   No Known  87-Sulfa	Box)  S  ((	DRMA State	Z Pho	IP (	Female			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.  City  Daytime Phone ( )  ALLERGIES:	Box)  S  (((inin))	State  Evening	Z Pho	IP (lis	Female Code			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.  City  Daytime Phone ( )  ALLERGIES:	Box)  S  ((initial continuous con	State  Evening	Z Pho ) Dither	IP (lis	Female  Code  t):			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.  City  Daytime Phone ( )  ALLERGIES:	S   E   (   (   (   (   (   (   (   (   (	State  Evening  Glauce- Stoma Thyroi Arthrit	Z Z Dther oma ach D d Disisis	IP (lis	Female  Code  t):			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.  City  Daytime Phone ( )  ALLERGIES:	S   E   (   (   (   (   (   (   (   (   (	State  Glauce Stoma Thyroid Arthritier (list)	Z Depther of the companies of the compa	IP (lis	Code tt):			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.  City  Daytime Phone ( )  ALLERGIES:	S   E   (   (   (   (   (   (   (   (   (	State  Evening  Glauce- Stoma Thyroi Arthrit	Z Depther of the companies of the compa	IP (lis	Code tt):			
Name (First, Last)  E-mail address  Date of Birth (MM/DD/YYYY)  Address (please do not use P.O.  City  Daytime Phone ( )  ALLERGIES:	S   E   (   (   (   (   (   (   (   (   (	Glauce-Stoma-Thyroi-Arthriter (list) ne (ve	Z Depther of the companies of the compa	IP (lis	Code tt):			